Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

BRAND ORAL SR OPIOID AGONISTS
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____Beneficiary's Medicaid #: _____

DOB:_____ City: _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____NPI: _____

City: _____ State: _____ Phone: _____

Fax: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact my subject me to civil penalties, fines or criminal prosecution.

_____ _____
Physician's Signature Date

PHARMACY INFORMATION

Dispensing Pharmacy:_____ Provider ID#:_____

City: _____State:_____ Phone: _____

Fax #:_____

DRUG/CLINICAL INFORMATION

Drug Name & Strength: _____ Quantity/Month: _____

Frequency:_____ Diagnosis:_____

Indicate asymmetrical dosing(if needed) ☐ am ☐ pm

List prior drug use:

1. _____ Length of therapy _____ days Reason for d/c_____

2. _____ Length of therapy _____ days Reason for d/c _____